Vermont Medicaid

Department of Human Services

Group Affiliation Request Form

Group Name _____ _____ Fax Form to 802-878-3440 Attn: Enrollment

Group Provider Number(s)_____

Service Location Address _____

(cannot be a PO Box) _____

_____

Handicap Accessible: Y__ No___ Language_____

Patient Age Limits: All_____Newborn:_____Age Range____to_____

Accepting New Patients: Y_____ No_____

Service Location address _____

(cannot be a PO Box) _____

_____

Handicap Accessible: Y__ No___ Language_____

Patient Age Limits: All_____Newborn:____Age Range;____to_____

Accepting New Patients: Y_____ No_____

New Group Member(s)

Provider Name (Please Print)	**Vt Medicaid Number**	**EFF DATE W/GROUP**	**NPI Number**	**Taxonomy**	**Requested by (Please Print)**

Signature of Requestor _____ **Date**_____